MEDICAL ASSISTANCE FINANCIAL PARTICIPATION IN PROVIDING SERVICES TO THE MENTALLY RETARDED:

IMPLICATIONS OF A VARIABLE STATE-COUNTY COST SHARE RATIO

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SUMMARY

CONTEXT

The Minnesota Department of Public Welfare (DPW) has developed a plan of action aimed at redirecting services for the mentally retarded from institutional and semi-institutional settings to in-home and community-based settings. By July of 1984 it hopes to obtain federal approval for Medical Assistance (MA) coverage of a new array of home and community-based services, called "waivered services" because approval hinges on a waiver request for MA coverage under Title XIX.

The 1983 legislature authorized a study, undertaken in December 1983 by Rainbow Research, Inc., to explore whether varying the state-county share of MA costs according to type of service would encourage counties to develop the new services more rapidly.

APPROACH

DPW staff suggested three policy options which the state might conceivably adopt. Each option presents a different financial participation rate for the STATE and COUNTY shares of services for MA-eligible clients. Currently the state pays 90 percent and counties pay 10 percent of the non-federal share for all services.

In each policy option, the state would pay a higher share of non-federal MA costs for waivered services, and a lower share for other services.

Under all three options a utilization target for state hospitals and community-based Intermediate Care Facilities (ICF/MR's) is calculated for each county, beyond which the state would pay only 75 percent of costs for ALL state hospital and ICF/MR services during the period for which the target was exceeded. The targets roughly reduce state hospital utilization by 30 percent between now and 1987, and ICF/MR utilization by 7 percent during the same period.

Our objective was to discover the fiscal, programmatic, administrative and political impact of each policy option in terms of the state's long-range policy goals.

Policy Option #1

Under Policy Option #1, the state-county shares of MA costs would vary by 5 percentage points as follows: 100-0% for in-home support services, 95-5% for other waivered services, 90-10% for small ICF/MR's, 85-15% for large ICF/MR's, and 80-20% for state hospitals.

Policy Option #2

Under Policy Option #2, the state-county shares of MA costs would be 95-5% for all waivered services, and 85-5% for all other services.

Policy Option #3

Under Policy Option #3, the state would pay 100 percent of the non-federal costs of all waivered services. State-county shares for other services would be: 90-10% for all ICF/MR's (the same as at present) and 80-20% for state hospitals.

The Study Respondents

We interviewed two types of respondents: county social service directors and a group of "policy stakeholders" or constituents who would be affected by the proposed policy options.

Constituents represented the foil owing groups: MR advocates, service providers, state officials and county associations.

A 20 percent sample of Minnesota counties was also chosen for an in-depth analysis of how each policy option would affect client movement and costs.

The sixteen counties who participated were stratified to represent a good "mix": some from each state hospital catchment area, and some of various levels of wealth, population and current utilization patterns. In this way the sample should be representative of the responses we would expect from all Minnesota counties.

The Study Method

All respondents received a written questionnaire by mail, followed up with a telephone -interview lasting from one half hour to two hours. County respondents also received several Worksheets to provide them with data about their current utilization and costs, their utilization targets, and to help them figure out projections of client movement and county costs under each of the policy options.

PROJECTED CLIENT PLACEMENTS AND COSTS, 1984-1987

Findings: Projected Client Movement

Every county in our sample projected the same client movement for each option, regardless of the county's cost burden. Most counties met or approximated the utilization targets established for purposes of the study.

We concluded that counties appear willing and ready to meet utilization targets under any cost-share system, that the specifics of the cost-share burden were secondary to other considerations, and that DPW's policy objectives might be successfully achieved simply by encouraging counties to meet these targets.

Findings: Projected Costs

Even under the least expensive policy option (Option #3), costs to counties would increase substantially between now and 1987, whether or not their utilization targets were met. Thus the options act as "disincentives" rather than incentives.

In most cases counties would meet their targets, and they project that 31 percent of all clients would be receiving waivered services by 1987. Nonetheless, none of the three policy options provides an opportunity for counties to realize cost savings.

The Summary Table attached shows total federal, state and county shares of MA costs between 1984 and 1987 under each policy option, under the present cost-share system and under an additional policy option discussed later. The present system is substantially cheaper for counties.

A further breakdown of costs by type of county reveals that high-utilizers of both state hospitals and ICF/MR's benefit somewhat more than low- and medium-utilizers.

These findings suggest that a variable cost-share ratio which acts as a "disincentive" rather than an incentive may not be an equitable or affordable system for encouraging movement of clients into waivered services.

However, these findings do not suggest what the impact might be of a cost-share ratio which would offer positive incentives for client movement.

Findings: Relative Costs to Counties and the State

Option #3 is the least costly to counties, increasing costs between 1984 and 1987 by 50 percent (while costs to the state would increase by 18 percent for the same period).

Under the present cost-share ratio county and state costs would both increase by 23 percent. This is a small increase considering that the total number of clients will increase by 15 percent while state hospital and ICF/MR costs are expected to increase from 20 to 40 percent. The net savings is due to movement into the less expensive waivered services.

Moreover, costs to counties decline proportionately after the first year (1985) when the option would take effect because more clients are placed in waivered services, suggesting that it is indeed possible to reduce normal cost increases by movement of clients into waivered services.

Were any of the policy options a positive incentive which would allow counties to realize actual dollar savings in the first few years, the gradual decline in normal cost increases resulting from continued client movement into waivered services would probably make such an option more desirable than the present system.

PROGRAMMATIC, ADMINISTRATIVE AND CONSTITUENT IMPACT

Findings: Encouragement of Waivered Services

Policy Option #3 is seen as most likely to encourage development of waivered services because of its relatively lower cost and the 100 percent state payment for those services. However, there was no great enthusiasm for this or for any of the policy options toward that end.

The consensus of responses seems to be that a variable cost-share ratio might encourage waivered services, but that other negative consequences would result from such a policy and that attention to non-cost factors might be more effective.

Findings: Quality of Care

The great majority of respondents believe that quality of care will not be assured, and may be jeopardized, through a policy which seeks rapid development and implementation of new services without providing guarantees of client-appropriateness and monitoring systems. While this never was DPW's intention in considering a fiscal policy, respondents seem to need more assurances on this point.

Many respondents also see a need for an education program about the uses and benefits of the various waivered service programs.

County case workers do not wish to make cost a factor in determining levels of services for their clients, and they see cost as unrelated to quality of care.

Findings: Necessary Administrative Changes

In general, counties believe that at least one additional staff person will be required to put the new services in place, especially under the time pressure associated with the policy options.

They also foresee administrative headaches associated with finding and monitoring new providers and with reactions from present providers, clients and their families, taxpayers and community residents and their county Boards.

Findings: Acceptability to Affected Constituents

In general, the greater the variance in cost-shares among the services, the greater the controversy the options would generate. Option #3 (most acceptable to counties because of overall costs) as well as Option #1 would be hard to sell to other constituents because of this discrepancy.

Objections to one or all of the options is diverse and widespread. Many of the concerns stem from the perception that change would be "forced" by imposing heavy cost penalties and that placement choices would be limited even where counties met previously established DPW goals.

The options as they are presently construed are not likely to gain acceptance.

Findings: Other Assessments

According to the study respondents, the cost-share ratio plans do not directly address many of the issues which arise from a policy of developing a new service delivery system. Some unanswered questions are: How will new clients become eligible for services? What mechanisms wi11 be built in for changes in individual clients' service needs? How will the waivered services be developed and implemented? Would an issue-focused approach be more effective than a cost incentive in encouraging change?

INCENTIVES AND DISINCENTIVES

We developed the following criteria for a fiscal incentive plan which might further DPW's long-range policy goals.

What the Incentive Should Do:

* The incentive should encourage counties to develop and utilize waivered services without losing cooperation from existing providers
* The incentive should allow sufficient development time for re-training of present providers who may wish to develop new services and for counties to develop quality control safeguards
* The incentive should reward counties for meeting the state's utilization targets

* The incentive should make it possible for continued movement of clients into waivered services to increase savings to the county over time

* The incentive should offer a positive impetus to counties to incur upfront development costs with the expectation that savings will be realized later

* The incentive should allow the state to share in the cost savings of the new services

What the Incentive Should Not Do

* The incentive should not put pressure on caseworkers to place clients solely on cost factors

* The incentive should minimize "polarization" of constituencies

* The incentive should not penalize counties for appropriate placements (such as movement of multiply handicapped clients from state hospitals to Class B ICF/MR's)

* The incentive should not increase the cost-share to counties for ANY services until enough new, less expensive services are in place so that their costs will not increase more than the state's projections of reasonable client movement

What Would an Incentive Look Like?

After studying the criteria outlined above and the projections of client movement done by the sample counties, we designed a variable cost-share ratio plan which might succeed in encouraging development of waivered services with minimal objections from counties and other stakeholders.

Under this plan, the present cost-share ratio would be maintained in 1984. In 1985 the ratio would change for waivered services, and in 1986 the ratio would change for state hospitals. This would allow counties time to move clients from state hospital settings without incurring increased costs. The cost-share ratio for ICF/MR's would not change at all.

How the Plan Meets Incentive Criteria

1) Counties are immediately encouraged to develop and utilize waivered services by the 95-5% cost-share ratio.

2) Cooperation from present providers is not lost because no one "loses", at least according to the sentiments expressed in reaction to the three options explored in this study:

* ICF/MR cost-share rates do not change.

* State hospitals, who have known for some time that their populations will be reduced, have two years before the county pays a greater share, time they can use to re-train staff, create new jobs, and participate in the development of the new services.

* Advocates, caseworkers and client families need not feel that inappropriate placements are made so that counties will avoid penalties.

3) Counties have an additional year of grace before their share of payments for any services are. increased, during which time they can develop new services with adequate safeguards, secure cooperation from Boards and taxpayers based on the potential cost savings, and begin client movement according to their own projections of what they can realistically achieve.

4) The counties which meet their state hospital utilization targets will not have to pay a disproportionate share for state hospital clients in 1986 (the first year in which their rate increases) because they will have moved sufficient numbers of clients to other services.

5) The percentage of cost increase (accounted for by inflation and new clients) to counties goes down from 9 percent in 1986 to 4 percent in 1987 despite the higher cost-share for state hospital placements. This is a net cost savings, and it happens because of the movement of more clients into waivered services. Moreover, we would expect even greater savings in subsequent years.

6) If no waivered services were developed, and if the present cost-share policy were maintained, we would expect costs for ICF/MR's and state hospital services to increase by at least 12 to 15 percent per year, not including costs for new clients. However, once the incentive plan takes effect, even including the influx of new clients neither the state nor the counties incur more than a 9 percent increase in any year, and the rate increase should continue

to decline. Thus the plan would meet federal requirements that the waivered services cost less than the present system.

7) The small net "savings" even in the first two years combined with the potentially greater savings in the future should encourage counties to invest time and even some funding in the development of waivered services, especially if the state or federal government makes development money available.

8) The state shares in the reduction of cost increases which result from client movement. Its cost increase between 1985 and 1987 remains constant at 6 percent, compared with an increase of 11 percent in 1984.

9) Because the incentive plan is based on caseworkers' own projections of appropriate movement of clients into waivered services, the counties can save money without fear of inappropriate placements.

10) ICF/MR providers will not be polarized because small and large facilities have the same cost-share ratio. State hospital providers will have less reason to complain that they are treated differently from ICF/MR's. Advocates will be satisfied because waivered services are rewarded but the counties will still share in the "risk" by paying some of the costs. Caseworkers will not be pressured by county Boards to cut costs regardless of client needs.

RECOMMENDATIONS: ENCOURAGING WAIVERED SERVICES

While waivered services were not directly the focus of this study, it was difficult for our respondents to separate the changes that will be necessary to establish a whole new system of services from the changes that would result from a fiscal incentive policy aimed at facilitating client movement in that system.

DPW staff suggested that the additional stress to counties and providers of a fiscal incentive plan might "overload" the system if introduced in the developmental stages of waivered services.

We concur, and would like to suggest more immediate steps which would facilitate development of the new system. Once these steps have been taken, the state would also be in a better position to judge the merits of a fiscal incentive plan, and counties and providers would be in a better position to profit by it.

Whether or not the state chooses to adopt a financial incentive plan, we recommend an integrated planning and implementation process. We see several critical elements to that process:

* An overall design plan for development of waivered services, developed by considering the total impact of waivered services and by further exploring the feasibility and consequences of an incentive plan.

* A set of guidelines for developing and monitoring waivered services and appropriate placement of clients.

* A technical assistance package for counties to orient them to the new services and to provide assistance in funding, training, development, and application. .

* An implementation plan which utilizes the knowledge and resources of current service providers and their staffs and affords them the opportunity to become providers of new services.

RECOMMENDATION: DESIGNING AN INCENTIVE PLAN

If the state wants its plan to act as an incentive, we recommend that it meet the criteria outlined above.

The incentive plan we have developed offers a policy whereby everyone "wins". The state and the counties save money (as is required for federal approval of the waiver request). Present service providers have time to re-direct their efforts and take part in the development of new services. Counties have time to assure that quality services will be developed, and to educate their communities about the advantages of the policy change. The goals of deinstitutionalization and "normalization" are served at minimal cost.

While an incentive plan has a number of desirable qualities, it does still create administrative difficulties, some inequities will necessarily remain, and several respondents will be opposed to having cost determine level of care in any way. DPW may wish to consider other means of achieving the de-institutionalization goals of its plan than by altering the present cost-share ratios.

We think that an incentive plan such as proposed in this section would be well-received, but this is conjecture. Perhaps this report could be circulated for response.

SUMMARY TABLE

SAMPLE COUNTY MA UTILIZATION AND COSTS FOR MR FACILITIES, PROJECTED 1984-87

	1984		1985		1986		1987	
	No. of Clients	Cost	No. of Clients	Cost	No. of Clients	Cost	No. of Clients	Cost
POLICY OPTION #1	3421		3642		3771		3932	
State share		$ 40,107,280		$ 41,934,764		$ 44,591,563		$ 47,421,817
County share		4,461,017		7,220,984		7,496,563		7,747,555
Federal share		49,340,630		55,496,028		58,810,388		62,285,170
Total		$ 93,908,927		$104,651,776		$110,898,514		$117,454,512
POLICY OPTION #2	3421		3642		3771		3932	
State share		$ 40,107,280		$ 42,084,539		$ 44,726,711		$ 47,523,722
County share		4,461,017		7,071,209		7,361,415		7,645,380
Federal share		49,340,630		55,496,028		58,810,388		62,285,170
Total		$ 93,908,927		$104,651,776		$110,898,514		$117,454,512
POLICY OPTION #3	3421		3642		3771		3932	
State share		$ 40,107,280		$ 42,698,728		$ 45,447,041		$ 48,378,586
County share		4,461,017		6,457,020		6,641,085		6,790,516
Federal share		49,340,630		55,496,028		58,810,388		62,285,170
Total		$ 93,908,927		$104,651,776		$110,898,514		$117,454,272
PRESENT COST-SHARE POLICY	3421		3642		3771		3932	
State share		$ 40,107,280		$ 44,238,020		$ 46,875,349		$ 49,647,718
County share		4,461,017		4,917,728		5,212,777		5,521,385
Federal share		49,340,630		55,496,028		58,810,388		62,285,170
Total		$ 93,908,927		$104,651,776		$110,898,514		$117,454,272
ADDITIONAL POLICY OPTION	3421		3642		3771		3932	
State share		$ 40,107,280		$ 44,238,020		$ 46,726,418		$ 49,584,252
County share		4,461,017		4,917,728		5,361,708		5,584,850
Federal share		49,340,630		55,496,028		58,810,388		62,285,170
Total		$ 93,908,927		$104,651,776		$110,898,514		$117,454,272

THE CONTEXT OF THE STUDY

The Minnesota Department of Public Welfare (DPW) has developed a plan of action which would redirect services for the mentally retarded from institutional and semi-institutional settings to in-home and community-based settings over the next five years. ("A Proposed Plan of Action for the Redesign of the Scope and Funding of Services for the Mentally Retarded in Minnesota," March 21, 1983.) This plan requires a number of legislative changes and significant alterations in modes of service delivery.

The plan was predicated on certain program policies:

1) To provide quality services in small, homelike and natural settings which are integrated into the mainstream of the community, and

2) To contain system cost increases in provision of services to the mentally retarded.

A large proportion of services are now paid by Medical Assistance (MA), with costs shared by the federal government (53.1%), state (42.2%) and counties (4.7%). By July of 1984 a new array of in-home and community-based services will probably become eligible for MA coverage upon approval by the federal government for a waiver request under Title XIX (December 8, 1983). The state wishes to encourage counties to develop these services and move clients into them rapidly.

The 1983 legislature (Article 9, Section 6, Subd. 3) authorized a study of the feasibility of varying the state-county cost-share ratios for MA-eligible services as a means of encouraging development and utilization of the new services.

In December 1983 Rainbow Research, Inc., was contracted to conduct a study to explore whether a variable cost-share ratio would in fact further the overall policy goals of DPW and the state.

We decided to examine the following consequences and implications of three variable cost-share ratios:

* Would varying the cost-share ratio facilitate client movement in the desired direction?

* What would be the costs to counties and to the state of several alternative cost-share ratios? How affordable would each of these alternatives be?

* What would be the programmatic impact of each alternative on quality of care?

* What administrative impact would each alternative have on the service delivery system?

* What would be the probable acceptance of each alternative (or any alternative) on affected constituents: county directors, caseworkers, MR advocates, clients and their families, service providers and their employees, taxpayers? What controversy would be generated?

APPROACH

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THE THREE POLICY OPTIONS

With the assistance of DPW staff, we designed three policy options which the state might conceivably adopt. Each of the policy options is aimed at facilitating the movement of mentally retarded persons into home and community-based settings. Each option presents a different financial participation rate for the STATE and COUNTY shares of services for MA-eligible clients.

Currently the state pays 90% of the non-federal share of costs for MA-covered services (i.e., state hospitals and community-based Intermediate Care Facilities (ICF/MR's); federal statute allows that this share be as low as 40%. The county pays the balance.

On the following pages the three policy options are explained. Each of these options explores a different method of changing the state's share (and therefore the county's share) of non-federal MA costs for various types of services. In each option, the state would pay a higher share of the MA costs for the home and community-based services with the intent of encouraging counties to develop and utilize them, These services are: in-home family support services, developmental training homes, supervised living arrangements (SLA'S) and semi-independent living services (SILS). These services are defined in DPW's waiver request of December 8, 1983 (and will hereafter be referred to as "waivered services").

Respite care, homemaker services and costs of case management are not being considered in this study.

Under each of the proposed options, the state's share would be equal to or less than its current share for community ICF/MR's and for state hospitals.

Finally, regardless of the option, a grace period would be provided so that counties could begin to make provisions for utilization of waivered services.

Our strategy was to ask each county, "What would happen if DPW adopted this policy?"

The County Utilization Target

In 1981 DPW considered the idea of developing utilization targets for maximal county placements in state hospital facilities, and polled counties about how that target should be calculated. The target numbers have not as yet been officially set by DPW. For purposes of this study we have assumed that the desired goal is to reduce statewide utilization of state hospitals by 30% and ICF/MR's by 7% by 1987.

The formula for state hospital utilization developed in 1981 by polling county welfare directors combined reduced per capita utilization by county with a 30% statewide, reduction so that counties with low utilization are not penalized .

We have used that formula in developing target numbers for each sample county.

Under all three options a utilization target for hospitals and community ICF/MR's is calculated for each county, beyond which the state would pay only 75 percent of costs for ALL state hospital and ICF/MR services during the period for which the target was exceeded.

POLICY OPTION #1

GRADUATED VARIABLE MA CONTRIBUTIONS

Under Policy Option #1, the state's share of MA costs for MR services would vary by 5 percentage points according to the type of service delivered, with the highest rate for in-home family support services and the lowest for state hospitals.

Under this proposed option, the state and county would pay the following percentages of the non-federal share:

		State	County
A.	In-home family support services	100%	0
B.	Other waivered services:		
	Developmental training homes (foster care)	95%	5%
	Supervised living arrangements (SLA'S)	95%	5%
	Semi-independent living services (SILS)	95%	5%
C.	Small group home (15 or less)	90%	10%
D.	Large group home (16 or more)	85%	15%
E.	State hospital	80%	20%

As in-all the options, if utilization of state hospitals and community ICF/MR's exceeded the target rate, the state's share for all of those services during that period would drop to 75 percent.

POLICY OPTION # 2

TWO RATES FOR STATE AND COUNTY SHARES

Under Policy Option #2, the state's share of reimbursement for the non-federal share of MA-covered clients would be 95% for all waivered services, and 85% for all non-waivered services.

Under this proposed option, the state and county would pay the following percentages of the non-federal share:

		State	County
A.	In-home family support services	95%	5%
B.	Other waivered services:		
	Developmental training homes (foster care)	95%	5%
	Supervised living arrangements (SLA'S)	95%	5%
	Semi-independent living services (SILS)	95%	5%
C.	Small group home (15 or less)	85%	15%
D.	Large group home (16 or more)	85%	15%
E.	State hospital	85%	15%

POLICY OPTION # 3

THREE VARIABLE RATES FOR STATE AND COUNTY SHARES

Under Policy Option #3, the state would pay 100% of the costs of waivered services, 90% (the same as at present) of the costs for large and small group homes, and 80% of the costs of state hospitals.

Under this proposed option, the state and county would pay the following percentages of the non-federal share:

		State	County
A.	In-home family support services	100%	0
B.	Other waivered services:		
	Developmental training homes (foster care)	100%	0
	Supervised living arrangements (SLA'S)	100%	0
	Semi-independent living services (SILS)	100%	0
C.	Small group home (15 or less)	90%	10%
D.	Large group home (16 or more)	90%	10%
E.	State hospital	80S	20%

THE STUDY RESPONDENTS

For this study we interviewed two types of respondents: county social service directors and a group of "policy stakeholders" or constituents who would be affected by the proposed policy options.

Constituents represented the following groups:

* MR advocates (Minnesota Association of Retarded Citizens, Legal Advocacy for the Developmentally Disabled),
* Service providers (Association of Residences for the Retarded in Minnesota, Minnesota DACA, AFSME, Faribault State Hospital, Woodvale Management Inc., Norhaven Inc.),
* State officials (Minnesota Developmental Disabilities Planning Office, a legislator, a court monitor), and
* Counties (County Social Service Director Association, Association of Minnesota Counties).

The Sample of Counties

A 20% sample of Minnesota counties was also chosen for an in-depth analysis of how each policy option would affect client movement and costs.

Seventeen counties were invited to participate in the study, and 16 responded. This sample was "stratified" to represent several key dimensions:

* metro/non-metro;
* high, medium and low utilization levels of community ICF/MR facilities and state hospital facilities;
* state hospital catchment area; and
* welfare caseload ratio in proportion to population (a measure of county wealth).

See Appendix A for breakdowns of the sample composition.

Generally, we tried to select a good "mix" of counties: some from each state hospital catchment area, and some of various levels of wealth, population and current utilization patterns.

Our method was to isolate counties first on the metro/non-metro dimension and then to look for patterns (such as "poor, low utilization state hospitals, high utilization ICF/MR" etc.). In this way the sample should be highly representative of the responses we would expect from all Minnesota counties.

The Interview Method

All respondents received a written questionnaire in the mail, with detailed instructions and explanations of each policy option. County respondents also received several Worksheets (see Appendix B) to provide them with data about their current utilization and costs, their target utilization quotas, and to help them figure out projections of client movement and county costs under each of the policy options.

The written questionnaire was followed by a telephone interview with Rainbow Research staff, in which questions about the study were answered and their responses to the questionnaire were recorded. This interview lasted from one half hour to two hours (and was often preceded by several phone calls with questions, because of the great difficulty of projecting what would happen "if"...)

Finally, two types of findings were compiled:

* A quantitative database of:

  A) projected client movement and projected costs under each policy option, and

  B) projected client movement and projected costs under the present cost-share system.

* A database of "qualitative" responses about fiscal, programmatic, administrative and other implications of each option and of a variable cost-share policy in general.

PROJECTED CLIENT PLACEMENTS AND COSTS, 1984-1987

HOW THE OPTIONS WOULD AFFECT CLIENT MOVEMENT

In the mailed questionnaires and over the phone, we asked county directors to review the three policy options and the utilization targets we set for their counties. Then we asked them to review their client caseload and project how many clients they would be able to move into waivered services between 1984 and 1987 (assuming that waivered services become MA-eligible in July of 1984 and that no policy option would take effect before 1985).

We also asked them to project how many new clients they anticipate during those four years and to place them in service categories along with present clients, explaining that ideally new clients would be placed in waivered services.

Our purpose was to discover which cost-share option would most affect the redistribution of clients.

Key Client Movement Findings

1) Every county in our sample projected the same client movement for each option, regardless of the county's cost burden.

2) Many counties told us that client placement is entirely unrelated to fiscal incentives.

3) Other counties said they are already committed to de-institutionalization and intend to pursue such a policy regardless of cost.

4) Still other counties said they would respond to an incentive system which encourages waivered services but only up to a level they consider feasible.

5) In general, counties reached or closely approximated the utilization targets we set for reducing utilization of state hospital and ICF/MR facilities. This suggests that the setting of targets alone might be a sufficient incentive for counties to meet them.

6) By 1987, counties project that 31 percent of all MA-eligible clients will be in waivered services. This by itself is an impressive achievement, and one which the counties maintain they will be able to do regardless of the state's choice of a cost-share ratio.

The Utilization Targets

Table 1 shows how the targets set for each sample county would or would not be met between 1984 and 1987.

From this table we see that:

1) The overall targets would be met.

2) Three counties would not meet their 1987 ICF/MR targets and only two counties would not meet its state hospital target. The counties unable to meet ICF/MR targets are all rural, are either poor or of medium wealth, and vary in their present utilization patterns. The counties which would not meet their state hospital targets are poor rural counties with high state hospital utilization.

3) The overall reduction which would be achieved in ICF/MR utilization between 1982 and 1987 is 8 percent (against a targeted 7 percent). State hospital utilization would be reduced by 32 percent for the same period (against a targeted 30 percent).

Summary

The most significant finding of the policy study so far is that sample counties, when presented with utilization targets for ICF/MR and state hospital facilities, express readiness and willingness to meet them, whether under a variable cost share ratio or under the present cost-share system.

This suggests that DPW might be as successful in achieving its policy objectives by encouraging counties to meet utilization targets as it would by implementing a variable cost-share ratio.

TABLE 1.

SAMPLE COUNTIES: TARGET UTILIZATION VS. PROJECTED UTILIZATION OF COMMUNITY-BASED ICF/MRS AND STATE HOSPITALS, 1984-1987

	ICF/MR No. of Clients					State Hospital No. of Clients				
County	1984	1985	1986	1987	1987 Target Met?	1984	1985	1986	1987	1987 Target Met?
BELTRAMI										
Target	55	54	53	52		19	18	16	14	
Projected	63	50	30	16	yes	18	16	14	10	yes
CARVER										
Target	41	40	39	38		17	16	15	14	
Projected	43	40	39	38	yes	17	16	15	14	yes
FARIBAULT										
Target	45	44	43	42		29	25	20	15	
Projected	40	35	30	25	yes	28	25	20	15	yes
HENNEPIN										
Target	1218	1196	1174	1153		506	467	427	387	
Projected	1218	1196	1174	1153	yes	506	467	427	387	yes
ISANTI										
Target	22	22	21	21		8	8	8	8	
Projected	21	22	22	22	yes	6	5	5	5	yes
ITASCA										
Target	58	57	56	55		27	25	22	19	
Projected	58	57	56	55	yes	27	25	22	19	yes
LAKE										
Target	12	12	11	11		12	11	9	7	
Projected	11	9	6	6	yes	11	11	11	11	no
MAHNOMEN										
Target	12	12	11	11		8	7	6	4	
Projected	12	12	12	13	no	7	6	6	5	no
MOWER										
Target	61	60	59	58	yes	34	30	26	22	
Projected	63	62	57	54	(except 1985)	30	28	25	22	yes
NOBLES										
Target	41	41	40	39		9	9	8	8	
Projected	41	41	40	40	no	9	9	8	8	yes
OLMSTED										
Target	146	143	140	135		32	31	30	29	
Projected	146	143	140	135	yes	32	31	30	29	yes
RED LAKE										
Target	4	4	4	4		12	10	8	6	
Projected	4	6	6	6	no	12	10	8	6	yes
RENVILLE										
Target	66	65	64	62		11	10	9	8	
Projected	65	63	62	61	yes	7	6	6	6	yes
RICE										
Target	66	65	64	62		34	31	27	23	
Projected	66	65	64	62	yes	34	31	27	23	yes
ST. LOUIS										
Target	270	266	261	256		127	117	106	96	
Projected	270	266	261	256	yes	127	117	106	96	yes
WASHINGTON										
Target	94	92	90	88		27	27	27	27	
Projected	94	92	90	88	yes	27	27	27	27	yes
TOTALS										
Target	2211	2173	2130	2087		912	842	764	687	
Projected	2215	2159	2089	2030	yes	898	830	757	683	yes

WHAT THE OPTIONS WOULD COST

Tables 2 through 5 show the total projected costs of the three policy options and of the status quo, using the counties' own projections of client movement. Costs are broken down by type of service, and by state, county and federal share.

Table 6 shows the total MA costs for 1981 and 1982, broken down by ICF/MR and state hospital utilization, and by state, county and federal share under the present cost-share ratio.

In developing cost projections, we used the figures for average costs of services given in DPW's waiver request of December 8, 1983. Obviously, these projections are only as accurate as these numbers and the projections of client movement done by sample counties. We were told by several respondents that these figures might be too low (in fact, some have been increased since the draft of the waiver request which we used in this study); therefore our cost totals should be seen as conservative.

Key Cost Findings

1) Each of the three policy options would substantially increase the counties' costs (and proportionately decrease the state's costs) for all MR services over what the costs would be if the present cost-share ratio were maintained.

2) Option #3 is the "cheapest" for the counties, raising total MR costs to them by about $2.3 million between 1984 and 1987 (not including any "penalties" which would-be incurred for not meeting utilization targets, which are virtually impossible to compute).

3) Most counties would not realize any cost savings, but rather their costs would increase dramatically under all the policy options even though they would meet or exceed their utilization targets and would move many clients into waivered services. Thus, the policy options should be viewed as "disincentives" rather than incentives.

4) The increase in total costs of all services between 1984 and 1987 is less than would be expected by ICF/MR and state hospital cost increases over that period, even if no new clients came into the system. Total costs of services increase from $93.9 million in 1984 to $117.4 million in 1987, an increase of 25 percent. DPW estimates that ICF/MR costs will increase by 28 percent and state

TABLE 2.

SAMPLE COUNTY MA UTILIZATION AND COSTS FOR MR FACILITIES, PROJECTED 1984-87

Policy Option: # 1

	Type of Service	1984 No. of Clients	1984 Cost	1985 No. of Clients	1985 Cost	1986 No. of Clients	1986 Cost	1987 No. of Clients	1987 Cost
A	In-home support	111		175		254		326	
	State share		$ 321,234		$ 590,975		$ 900,684		$ 1,213,698
	County share		35,742		-0-		-0-		-0-
	Federal share		403,041		667,275		1,017,016		1,370,504
	Sub-Total		$ 760,017		$ 1,258,250		$ 1,917,700		$ 2,584,202
B	Other waivered services	197		478		671		893	
	State share		$ 865,618		$ 2,341,244		$ 3,471,083		$ 4,873,994
	County share		96,333		123,324		182,512		256,291
	Federal share		108,864		2,782,438		4,124,637		5,791,998
	Sub-Total		$ 1,070,815		$ 5,247,006		$ 7,778,232		$ 10,922,283
C	Small ICF/MR	1172		1158		1108		1074	
	State share		$ 12,095,040		$ 13,334,370		$ 13,680,476		$ 14,166,060
	County share		1,345,456		1,482,240		1,521,284		1,575,558
	Federal share		15,173,884		16,727,310		17,164,028		17,771,478
	Sub-Total		$ 28,614,380		$ 31,543,920		$ 32,365,788		$ 33,513,096
D	Large ICF/MR	1043		1001		981		956	
	State share		$ 10,763,760		$ 10,885,875		$ 11,439,441		$ 11,908,892
	County share		1,197,364		1,921,920		2,019,879		2,103,200
	Federal share		13,503,721		14,459,445		15,196,671		15,818,932
	Sub-Total		$ 25,464,845		$ 27,267,240		$ 28,655,991		$ 29,831,024
E	State hospital	898		830		757		683	
	State share		$ 16,061,628		$ 14,782,300		$ 15,099,879		$ 15,258,903
	County share		1,786,122		3,693,500		3,772,888		3,812,506
	Federal share		20,151,120		20,859,560		21,308,036		21,532,258
	Sub-Total		$ 37,998,870		$ 39,335,360		$ 40,180,803		$ 40,603,667
	Totals - All Services	3421		3642		3771		3932	
	State share		$ 40,107,280		$ 41,934,764		$ 44,591,563		$ 47,421,817
	County share		4,461,017		7,220,984		7,496,563		7,747,555
	Federal share		49,340,630		55,496,028		58,810,388		62,285,170
	TOTAL *		$ 93,908,927		$104,651,776		$110,898,514		$117,454,512

TABLE 3.

SAMPLE COUNTY MA UTILIZATION AND COSTS FOR MR FACILITIES, PROJECTED 1984-87

Policy Option: #2

	Type of Service	1984 No. of Clients	1984 Cost	1985 No. of Clients	1985 Cost	1986 No. of Clients	1986 Cost	1987 No. of Clients	1987 Cost
A	In-home support	111		175		254		326	
	State share		$ 321,234		$ 561,400		$ 855,726		$ 1,153,062
	County share		35,742		29,575		44,958		60,636
	Federal share		403,041		667,275		1,017,016		1,370,504
	Sub-Total		$ 760,017		$ 1,258,250		$ 1,917,700		$ 2,584,202
B	Other waivered services	197		478		671		893	
	State share		$ 865,618		$ 2,341,244		$ 3,471,083		$ 4,873,994
	County share		96,333		123,324		182,512		256,291
	Federal share		108,864		2,782,438		4,124,637		5,791,998
	Sub-Total		$ 1,070,815		$ 5,247,006		$ 7,778,232		$ 10,922,283
C	Small ICF/MR	1172		1158		1108		1074	
	State share		$ 12,095,040		$ 12,593,250		$ 12,920,388		$ 13,378,818
	County share		1,345,456		2,223,360		2,281,372		2,362,800
	Federal share		15,173,884		16,727,310		17,164,028		17,771,478
	Sub-Total		$ 28,614,380		$ 31,543,920		$ 32,365,788		$ 33,513,096
D	Large ICF/MR	1043		1001		981		956	
	State share		$ 10,763,760		$ 10,885,875		$ 11,439,441		$ 11,908,892
	County share		1,197,364		1,921,920		2,019,879		2,103,200
	Federal share		13,503,721		14,459,445		15,196,671		15,818,932
	Sub-Total		$ 25,464,845		$ 27,267,240		$ 28,655,991		$ 29,831,024
E	State hospital	898		830		757		683	
	State share		$ 16,061,628		$ 15,702,770		$ 16,040,073		$ 16,208,956
	County share		1,786,122		2,773,030		2,832,694		2,862,453
	Federal share		20,151,120		20,859,560		21,308,036		21,532,258
	Sub-Total		$ 37,998,870		$ 39,335,360		$ 40,180,803		$ 40,603,667
	Totals - All Services	3421		3642		3771		3932	
	State share		$ 40,107,280		$ 42,084,539		$ 44,726,711		$ 47,523,722
	County share		4,461,017		7,071,209		7,361,415		7,645,380
	Federal share		49,340,630		55,496,028		58,810,388		62,285,170
	TOTAL		$ 93,908,927		$104,651,776		$110,898,514		$117,454,512

TABLE 4.

SAMPLE COUNTY MA UTILIZATION AND COSTS FOR MR FACILITIES, PROJECTED 1984-87

Policy Option: #3

	Type of Service	1984 No. of Clients	1984 Cost	1985 No. of Clients	1985 Cost	1986 No. of Clients	1986 Cost	1987 No. of Clients	1987 Cost
A	In-home support	111		175		254		326	
	State share		$ 321,234		$ 590,975		$ 900,684		$ 1,213,698
	County share		35,742		-0-		-0-		-0-
	Federal share		403,041		667,275		1,017,016		1,370,504
	Sub-Total		$ 760,017		$ 1,258,250		$ 1,917,700		$ 2,584,202
B	Other waivered services	197		478		671		893	
	State share		$ 865,618		$ 2,464,568		$ 3,653,595		$ 5,130,285
	County share		96,333		-0-		-0-		-0-
	Federal share		108,864		2,782,438		4,124,637		5,791,998
	Sub-Total		$ 1,070,815		$ 5,247,006		$ 7,778,232		$ 10,922,283
C	Small ICF/MR	1172		1158		1108		1074	
	State share		$ 12,095,040		$ 13,334,370		$ 13,680,476		$ 14,166,060
	County share		1,345,456		1,482,240		1,521,284		1,575,558
	Federal share		15,173,884		16,727,310		17,169,028		17,771,478
	Sub-Total		$ 28,614,380		$ 31,543,920		$ 32,365,788		$ 33,513,096
D	Large ICF/MR	1043		1001		981		956	
	State share		$ 10,763,760		$ 11,526,515		$ 12,112,407		$ 12,609,640
	County share		1,197,364		1,281,280		1,346,913		1,402,452
	Federal share		13,503,721		14,459,445		15,196,671		15,818,932
	Sub-Total		$ 25,464,845		$ 27,267,240		$ 28,655,991		$ 29,831,024
E	State hospital	898		830		757		683	
	State share		$ 16,061,628		$ 14,782,300		$ 15,099,879		$ 15,258,903
	County share		1,786,122		3,693,500		3,772,688		3,812,506
	Federal share		20,151,120		20,859,560		21,308,036		21,532,258
	Sub-Total		$ 37,998,870		$ 39,335,360		$ 40,180,603		$ 40,603,667
	Totals - All Services	3421		3642		3771		3932	
	State share		$ 40,107,280		$ 42,698,728		$ 45,447,041		$ 48,378,586
	County share		4,461,017		6,457,020		6,641,085		6,790,516
	Federal share		49,340,630		55,496,028		58,810,388		62,285,170
	TOTAL		$ 93,908,927		$104,651,776		$110,898,514		$117,454,272

TABLE 5.

SAMPLE COUNTY MA UTILIZATION AND COSTS FOR MR FACILITIES, PROJECTED 1984-87

Policy Option: Present Policy

	Type of Service	1984 No. of Clients	1984 Cost	1985 No. of Clients	1985 Cost	1986 No. of Clients	1986 Cost	1987 No. of Clients	1987 Cost
A	In-home support	111		175		254		326	
	State share		$ 321,234		$ 531,825		$ 810,514		$ 1,092,100
	County share		35,742		59,150		90,170		121,598
	Federal share		403,041		667,275		1,017,016		1,370,504
	Sub-Total		$ 760,017		$ 1,258,250		$ 1,917,700		$ 2,584,202
B	Other waivered services	197		478		671		893	
	State share		$ 865,618		$ 2,217,920		$ 3,287,900		$ 4,616,810
	County share		96,333		246,648		365,695		513,475
	Federal share		108,864		2,782,438		4,124,637		5,791,998
	Sub-Total		$ 1,070,815		$ 5,247,006		$ 7,778,232		$ 10,922,283
C	Small ICF/MR	1172		1158		1108		1074	
	State share		$ 12,095,040		$ 13,334,370		$ 13,680,476		$ 14,166,060
	County share		1,345,456		1,482,240		1,521,284		1,575,558
	Federal share		15,173,884		16,727,310		17,169,028		17,771,478
	Sub-Total		$ 28,614,380		$ 31,543,920		$ 32,365,788		$ 33,513,096
D	Large ICF/MR	1043		1001		981		956	
	State share		$ 10,763,760		$ 11,526,515		$ 12,112,407		$ 12,609,640
	County share		1,197,364		1,281,280		1,346,913		1,402,452
	Federal share		13,503,721		14,459,445		15,196,671		15,818,932
	Sub-Total		$ 25,464,845		$ 27,267,240		$ 28,655,991		$ 29,831,024
E	State hospital	898		830		757		683	
	State share		$ 16,061,628		$ 16,627,390		$ 16,984,052		$ 17,163,107
	County share		1,786,122		1,848,410		1,888,715		1,908,302
	Federal share		20,151,120		20,859,560		21,308,036		21,532,258
	Sub-Total		$ 37,998,870		$ 39,335,360		$ 40,180,803		$ 40,603,667
	Totals - All Services	3421		3642		3771		3932	
	State share		$ 40,107,280		$ 44,238,020		$ 46,875,349		$ 49,647,718
	County share		4,461,017		4,917,728		5,212,777		5,521,385
	Federal share		49,340,630		55,496,028		58,810,388		62,285,170
	TOTAL		$ 93,908,927		$104,651,776		$110,898,514		$117,454,272

TABLE 6.
SAMPLE COUNTY MA UTILIZATION AND COSTS FOR MR FACILITIES
ACTUAL, 1981 AND 1982

	1981		1982	
	No. of Clients	Cost	No. of Clients	Cost
Total ICF/MR	1,815		2,167	
State Share		$13,799,766		$14,311,259
County Share		1,534,397		1,591,268
Federal Share		17,312,565		17,954,249
Sub-Total		$32,646,738		$33,856,776
State Hospital	1,043		998	
State Share		$11,173,405		$13,018,759
County Share		1,242,370		1,447,556
Federal Share		14,017,640		16,332,737
Sub-Total		$26,433,415		$30,799,052
Totals - All Services	2,858		3,165	
State Share		$24,973,171		$27,330,018
County Share		2,776,767		3,038,824
Federal Share		31,330,205		34,286,986
TOTALS		$59,080,143		$64,655,828

hospital costs by over 40 percent during that period. The costs of waivered services, however, are expected to increase only by about 17 percent.

5) However, new clients will come into the system: an estimated 511 new clients between 1984 and 1987 alone or an increase of 15 percent. Therefore, it appears that a cost savings (over what would be expected without any waivered services) of at least 15 percent is achieved by movement of clients into waivered services.

6) The counties, under any of the three options, would realize none of this "savings". In fact, the counties' share of the costs even under the cheapest option (#3) will be increased by 52.2 percent.

Summary

In sum, although counties maintain that they will in fact be able to move a substantial number of clients (31 percent) into waivered services by 1987, and although most will be able to meet utilization targets for state hospitals and ICF/MR's, none of the three policy options provides an opportunity for counties to realize cost savings. Rather, their costs would increase substantially over what would be expected by inflation alone even under the least expensive option.

COUNTY COSTS BY TYPE OF COUNTY

We wanted to learn whether a disproportionate share of the MA costs for MR services would be borne by any "type" of county under a cost-share ratio plan. For example, would such a plan cause poorer counties to pay more than others in proportion to their relative numbers of clients?

Because Option #3, by virtue of its lower cost to counties, is really the only feasible option, we did not look at any of the others for this analysis.

Tables 7 through 10 show breakdowns of number of clients and county costs on these dimensions: metro/non-metro, ICF/MR utilization, state hospital utilization, and welfare caseload ratio ("wealth").

TABLE 7.

SAMPLE COUNTY MA UTILIZATION. AND COSTS FOR MR FACILITIES, BROKEN DOWN BY METRO/NON-METRO
PROJECTED 1984-1987 FOR POLICY OPTION #3

	1984	% Total	1985	% Total	1986	% Total	1987	% Total
All Services:								
Metro	2,588	76%	2,776	76.2%	2,865	76%	2,976	76%
No. of Clients County	$3,427,588	76.8%	$5,029,060	77.9%	$5,226,605	78.7%	$5,402,850	79.6%
Cost								
All Services:								
Non-Metro	833	24%	866	24%	906	24%	956	24%
No. of Clients County	$1,033,429	23%	$1,427,960	22%	$1,414,480	21 %	$1,387,674	20%
Cost								

TABLE 8.
SAMPLE COUNTY HA UTILIZATION AND COSTS FOR MR FACILITIES, BROKEN DOWN BY ICF/MR UTILIZATION
PROJECTED 1984-1987 FOR POLICY OPTION #3

	1984	% Total	1985	% Total	1986	% Total	1987	% Total
All Services:								
High Utilization								
No. of Clients	233	7%	247	7%	258	7%	271	7%
County Cost	$293,390	7%	$397,980	6%	$397,072	6%	$396,161	6%
All Services:								
Medium Utilization								
No. of Clients	2,953	86%	3,151	87%	3,257	86%	3,390	86%
County Cost	$3,885,410	87%	$5,658,070	88%	$5,819,577	88%	$5,944,323	88%
All Services:								
Low Utilization								
No. of Clients	235	7%	244	7%	256	7%	271	7%
County Cost	$282,247	6%	$400,970	6%	$424,436	6%	$452,492	7%

TABLE 9.

SAMPLE COUNTY MA UTILIZATION AND COSTS FOR MR FACILITIES, BROKEN DOWN BY STATE HOSPITAL UTILIZATION
PROJECTED 1984-1987 FOR POLICY OPTION #3

	1984	% Total	1985	% Total	1986	% Total	1987	% Total
All Services:								
High Utilization								
No. of Clients	170	4.8%	178	4.8%	182	4.8%	188	4.8%
County Cost	$207,446	4.7%	$310,760	4.8%	$298,422	4.5%	$297,884	4.1%
All Services:								
Medium Utilization								
No. of Clients	2,766	80.8%	2,957	81.2%	3,052	80.9%	3,176	80.8%
County Cost	$3,650,140	81.8%	$5,337,080	82.6%	$5,477,837	82.5%	$5,584,400	82.2%
All Services:								
Low Utilization								
No. of Clients	485	14%	507	13.9%	537	14.2%	568	14.4%
County Cost	$598,681	13.4%	$809,180	12.5%	$864,826	13%	$926,232	13.6%

TABLE 10.

SAMPLE COUNTY MA UTILIZATION AND COSTS FOR MR FACILITIES, BROKEN DOWN BY CASELOAD RATIO
PROJECTED 1984-1987 FOR POLICY OPTION #3

	1984	% Total	1985	% Total	1986	% Total	1987	% Total
All Services: High Caseload								
Ratio No. of Clients	675	20%	753	20%	779	21%	828	21%
County Cost	$884,895	20%	$1,283,070	20%	$1,293,599	20%	$1,294,644	20%
All Services: Medium Caseload								
Ratio No. of Clients	2,289	67%	2,405	66%	2,481	65%	2,562	65%
County Cost	$2,958,211	66%	$4,336,600	67%	$4,478,429	67%	$4,601,840	68%
All Services: Low Caseload								
Ratio No. of Clients	457	13%	484	13%	511	13%	542	14%
County Cost	$591,829	13%	$837,350	13%	$869,055	13%	$894,032	13%

Metro Counties' Costs Slightly Higher

Table 7 shows that in 1984 (before Option #3 takes effect), metro counties pay about 3 percent more than non-metro counties proportionate to client population. By 1987 their share of costs is about 4 percent higher. This is because they are using more of the higher-cost, non-waivered services and probably explained by the fact that more large care facilities are located in metro areas. Such a difference should not present a problem for metro counties with a large tax base but could cause difficulties for a poor metro area (i.e., St. Louis County).

Costs Slightly Lower with High Utilization of ICF/MR's

In 1984 (i.e., the present cost-share ratio) the counties with low utilization of ICF/MR facilities pay a slightly smaller percentage (1% smaller) of total care costs than high- and medium-utilization counties. However, by 1987 this "advantage" is lost, and high-utilization counties get this same cost "break". While the difference is a small one, it is an indication that counties who already have kept ICF/MR utilization down will have to pay more than those who have not. This is because they are less able to reduce ICF/MR utilization, which is more costly than waivered services, than other counties can.

Costs Slightly Lower with High Utilization of Hospitals

In 1984 low utilizers of state hospitals are expected to pay very slightly less than high- or medium-utilizers for total care. By 1987 under Policy Option #3, high-utilizers costs are somewhat reduced while medium-utilizers are somewhat increased and low utilizers remain roughly the same. Therefore, while Option #3 does not greatly change the present pattern of relative cost burdens, what benefit does accrue goes to high-utilizers.

However, a goal of the policy options is to reduce state hospital utilization. We heard from some respondents that low-utilizing counties have already made substantial efforts to move clients out of state hospitals and they feel that it is unfair to "change the rules" to reward counties who have not already done so. And while this option does not actually penalize counties who are already low-utilizers, they are clearly not beneficiaries.

Again, it should be easier to reduce utilization where it is high and in fact the DPW targets require that this be done. Therefore, a low-utilizing county which meets its target is in a less advantageous cost position than a high-utilizing county which meets its target.

Again, the differences in proportionate costs are small. Nonetheless we suggest that they are inequitable to those counties who have already made strides in the desired direction.

Costs Highest for Medium-Caseload Counties

In Table 10 we see that under the present cost-share system (1984) counties bear identical proportions of cost regardless of their overall caseload ratio. Counties with the highest caseload ratios tend to be the poorest, those with low caseload ratios the wealthiest. Thus, the present system may be said to impose an equal "burden" regardless of wealth or poverty.

By 1987 the poorest counties and richest counties both benefit very slightly (1 percent) relative to counties of medium wealth. (This finding is probably explained in large part by the fact that Hennepin County has a medium caseload ratio, that its costs increase greatly, and that it accounts for about half of the total clients in this sample).

If we can discount the fact that wealthier counties are less burdened by the changes brought about under this policy option, it is probably fair to say that at least poorer counties are not relatively worse off than they were before. Nonetheless, they are still heavily burdened by the increased costs that this option will incur, and are probably without a sufficient tax base to support it.

Summary

As noted above, Hennepin County accounts for about half of the clients in our sample. Because it is classified as "medium" on both categories of utilization and on wealth, we would expect the differences we have seen for the highest and lowest counties to be exacerbated were Hennepin not included in this analysis.

Differences in relative cost shares were not great for any breakdown, but we see that the high-utilizers of both state hospitals and ICF/MR's, the non-metro counties, and the poorest and wealthiest counties benefit the most by the policy change in comparison with all other categories.

We suggest that a fiscal policy should not reward high-utilizers disproportionately, although this is an inevitable result of its utilization targets. We also suggest that poor and non-metro counties, even where they are not "more" burdened than other counties, will still be hard put to raise the additional money required to pay for services under Option #3.

The net result of this analysis suggests that a variable cost-share ratio which is a financial disincentive may not be an equitable or affordable system for encouraging movement of MR clients into in-home and community-based services.

It does not, however, consider the impact of a cost-share ratio which would offer positive incentives for client movement, which we will discuss in a later section of this report.

RELATIVE COSTS TO COUNTIES AND THE STATE BY OPTIONS

The three options can be compared to reveal which 1s likely to be most costly to counties. Table 11 shows the percentage increases in costs for each policy option between 1984 and 1987, broken down by state and county shares and compared with the total increase.

TABLE 11.
PERCENTAGE INCREASES IN MA-COVERED COSTS 1984-1987
FOR STATE AND COUNTY, BY POLICY OPTION

	1985 % Increase	1986 % Increase	1987 % Increase
Total Costs (All options)	11%	6%	6%
Option #1:	62%	4%	3%
County State	5%	6%	6*
Option #2:	60%	4%	4%
County State	5%	6%	6%
Option #3:	45%	3%	2%
County State	6%	6%	6%
Present Policy:	11%	6%	6%
County State	11%	6%	6%

From this table we can make some comparisons:

1) Under all three policy options costs to counties increase substantially over what they would be if the status quo were maintained.

2) All of this increase occurs during the first year (1985) because of the great discrepancy between the cost formulas and the fact that few clients have by then been placed in waivered services.

3) After that, the counties' costs do not increase as much as the state's (in proportion to total cost increases) between 1985 and 1987. This relatively small advantage accrues to counties because they are moving more clients into waivered services.

4) If Policy Option #3 were adopted, and if counties could continue to move clients into waivered services at the rates they project between 1984 and 1987, it would take 12 to 15 years for them to offset the initial cost increase engendered by the policy and begin to realize an actual savings. The other options would take even longer.

5) Policy Option #3 is clearly the most desirable for counties because its initial cost burden is the lowest and the percentage increase in costs for services for each subsequent year is also lowest. This option still allows the state to save substantially over the cost increases which would be expected without MA-coverage for waivered services.

6) Table 11 suggests that it is indeed possible to reduce normal cost increases for MR services by movement of clients into waivered services, even if new clients come into the system.

7) Were any of the policy options a positive incentive which would allow counties to realize actual dollar savings in the first few years, the decline in proportionate cost increases between 1985 and 1987 would probably make such an option more desirable to counties than the status quo.

ADDITIONAL COST FACTORS

We asked the study respondents to consider the economic impact of the policy options on sample counties and the state as a whole. Their comments fell into three categories: statewide effects, regional effects, and effects on individual counties, and are summarized below.

Comments About Statewide Impact

1) Assuming that costs for waivered services are in fact cheaper than for present services, the state as a whole will realize a cost savings as these services are developed and utilized. (However, we also heard that some people think that waivered services will cost more than anticipated.)

2) This study does not consider services funded under other programs (such as CSSA and DAC's) how they will be affected by waivered services, but only how MA costs will be affected, and therefore the statewide impact of changing the system as a whole remains an unknown.

3) New clients will become eligible for HA assistance through the waivered services, including both high-functioning adults and children who can receive in-home support services early in their lives. While this will increase costs of services initially, in the long run it should be advantageous to the state. Reasons include: avoidance of the costs which might be incurred for these clients at some stage in their lives by placement in large, higher-cost facilities; and the likelihood that they will function more productively, decreasing costs for support services later and increasing their contributions as workers and taxpayers.

4) Money for services will be more widely dispersed throughout the state as waivered service providers gradually replace large providers.

Comments About Regional Impact

1) State hospital communities will be adversely affected. Jobs will be lost and the local economy wi11 suffer hardship.

2) New employment opportunities will open for waivered service providers.

3) Sparsely populated areas will find it more difficult to develop waivered services and find providers. Clients may be sent to the Twin Cities metro area to obtain services, as it will be easier to develop them here. However, the costs of developing services in the metro area will probably also be higher.

Comments About County Impact

1) The increased costs for MA services would be a severe hardship for most sample counties.

2) Some said they would have no choice but to meet the new costs, but that because their Boards would probably not approve an increased budget or raise the tax levy, they would have to cut other social service programs, which would probably generate difficult political struggles.

3) The options in which 100% of costs for waivered services would be paid by the state would be most attractive to county Boards. However, several respondents also commented that this would be a bad idea because then the county would not have a share in the risk for the waivered service clients. Since they are responsible for case management decisions, this was not viewed as a desirable situation.

4) The options do not reflect the administrative costs associated with developing new services. Most counties indicated that they would need additional staff, which they could afford only with difficulty.

5) Counties expect that new hidden costs will 6e associated with developing new services: some clients will fail and need stabilization, overhead costs will increase, new client needs will emerge, and initial cost projections are probably too low anyway.

6) The penalties associated with not moving clients fast enough may also incur additional costs; in effect, making the time needed to develop new services more costly.

7) Moving clients who are multiply handicapped or have severe behavior problems out of state hospitals may require development of new Class B facilities to handle their needs appropriately, which would incur large costs. However, there is no financial advantage to developing such facilities under the options nor any reward for such movement of clients. In fact, there may be a further penalty if the number of ICF/MR clients placed in Class B facilities brings the county over the ICF/MR target.

8) Poor rural counties will be unable to find trained providers locally, and will have great difficulty attracting new, for-profit service providers.

9) Counties may also face pressure to provide the new waivered services to non-MA-eligible clients.

Summary

Although the state as a whole may in time realize savings through the development of less expensive services, the policy options would impose immediate and severe financial hardships on most counties and on state hospital communities. However, reduction in state hospital populations may be less of a hardship because it is simply an extension of a previously established policy direction.

PROGRAMMATIC, ADMINISTRATIVE, AND CONSTITUENT IMPACT

In this section we will summarize the comments made by our respondents about each of the policy options and about the desirability of a variable cost-share ratio in general, with respect to:

* encouragement of waivered services
* quality of care
* necessary administrative changes
* acceptability to affected constituents
* other assessments

KEY FINDINGS: ENCOURAGEMENT OF WAIVERED SERVICES

We asked each of our respondents whether the policy options would in fact encourage development of waivered services, and which option would be most effective in doing so. Their comments are summarized below.

1) Most respondents chose Option #3 as the one which would most likely encourage development of waivered services. County respondents prefer this option because it is clearly the cheapest. Many constituents pointed out that this option is an incentive because it covers all the costs of the waivered services. But many other constituents expressed reservations about this option (described later).

2) In discussions about each of the policy options, respondents tended not to perceive them as very different from each other. The few differences that were cited as important were: whether the state pays 95% or 100% for waivered services, whether small and large ICF/MR's have different cost-share rates, and what the share of state hospital costs would be. However, opinions were strongly divided about the advantages and disadvantages of these differences.

3) Constituents were more likely than counties to believe that any of the policy options would encourage waivered services, typically saying that they probably would. However, they did not learn from their participation in the study (as the counties did) that all of the options would substantially increase county costs.

4) Counties were about equally divided as to whether any option would encourage waivered services. In general, those who thought that they would saw the penalty for not doing so as the motivating factor. Those who thought they would not saw the burden of increased costs (especially the administrative costs of setting up the new services) being so great as to offset any other factor.

5) Many respondents qualified their answers by saying that a fiscal incentive or disincentive might be effective, but that the present system would also be effective. They also identified variables other than the cost share as of equal importance in motivating client movement, such as: assistance in developing the new services, the needs of present clients, relationships with providers, activities of advocacy groups, professional biases, emotional biases of the general population, and the range of options available.

6) Most respondents were careful in their answers to this question to separate the question of fiscal incentives from the question of quality of care. While they indicated that cost factors might induce counties to shift services, they stressed that there is no connection between cost and quality of care.

Summary

Policy Option #3 is seen as most likely to encourage development of waivered services because of its relatively lower cost and the 100% state payment for those services. However, there was no great enthusiasm for this or for any of the policy options toward that end.

The consensus seems to be that a variable cost-share ratio, might encourage waivered services, but that other negative consequences (discussed in the following sections) would result from such a policy and that attention to non-cost factors might be more effective.

KEY FINDINGS: QUALITY OF CARE

We asked all respondents how each of the policy options would affect overall quality of care. There were virtually no differences in the answers for individual policy options. The responses summarized below apply equally to all of the options.

1) The factors which determine quality of care are complex. "Normalization" of living environment, which might result more rapidly if one of the policy options were adopted, is only one dimension,

2) Other equally important dimensions include: monitoring systems, accreditation, licensing, standards, performance contracts, client-appropriateness of services, client outcome measures, client/parent preferences, and availability of choices.

3) If development of waivered services and movement of clients occurs too fast without allowing time for appropriate quality control mechanisms, the effects on clients could be harmful. "Fly-by-night" providers might come in, or clients might be moved into a situation where they would fail. Also, the necessity to establish monitoring services would dictate heavy costs. Counties will need considerable technical assistance, financial assistance and education in setting up a workable system of alternative services.

4) Quality of care is best assured in a system where many choices are available, depending on client needs. To the extent that the options reduce choices they will discourage quality. For example, many respondents said that good facilities for the multiply handicapped are already scarce, and that a policy which reduces ICF/MR utilization without taking into account the special needs of this group (which are best served there) will be detrimental to their interests.

5) Many counties said that they would not use a cost basis to determine the appropriate level of service for a client.

6) The standards and per diem rates for various service levels which would be set by the state would be more important factors 1n assuring quality of care than a variable state-county cost-share ratio.

7) Some of the smaller counties seem to be especially uninformed about the value and advantages of moving clients into smaller, community-based settings and about the new services which will become MA-eligible under the waiver request. Some respondents suggested that a 2-day seminar

for all counties explaining the waivered services program in detail would be more effective than a fiscal policy in helping counties to realize the advantages to clients of the waivered services options.

Summary

The great majority of respondents believe that quality of care will not be assured, and may be jeopardized, through a policy which seeks rapid development and implementation of new services without providing guarantees of client-appropriateness and monitoring systems. While this never was DPW's intention in considering a fiscal policy, respondents seem to need more assurances on this point.

Many respondents also see a need for an education program about the uses and benefits of the various waivered service programs.

County case workers do not wish to make cost a factor in determining levels of services for their clients, and they see cost as unrelated to quality of care.

KEY FINDINGS: NECESSARY ADMINISTRATIVE CHANGES

1) Some of the administrative changes which counties see as required in order to develop and administer waivered services quickly enough to avoid financial penalties under the options are:

* Hiring and training new staff
* Developing procedures for case management and payment
* Securing bids, screening and finding new providers
* Setting up support services and respite care

  both of which will be needed with waivered services
* Setting up contracts for waivered services
* Licensing new providers
* Setting up a monitoring system to safeguard against abuse.

2) Administrative problems foreseen include:

* Re-defining relationships with present providers
* Levy raises to allow hiring new staff and cover increased county shares of costs
* Finding Class B facilities for the multiply handicapped
* Finding foster homes suitable for children and disabled adults (already a problem)
* Community acceptance of state hospital clients
* Community acceptance of waivered services
* Need to return some state hospital clients for temporary stays (how would this affect the utilization targets?)
* "It's a monopoly system. You can't put out an RFP on service providers."
* Appeals and legal challenges from people who don't want to move
* Appeals from new clients unable to get waivered services (many now on waiting lists, many more will want services when available)
* Pressure from parents and advocates about appropriate placement and safety
* Relationships with providers in other counties where clients are placed
* Waiting lists for state hospitals and ICF/MR's will grow as targets limit placements
* Taxpayer and Board pressure to move clients quickly to avoid increased costs.

Summary

In general, counties believe that at least one additional staff person will be required to put the new services in place, especially under the time pressure associated with the policy options. They also foresee administrative headaches associated with finding and monitoring new providers and with reactions from present providers, clients and their families, taxpayers and community residents and their county Boards.

KEY FINDINGS: ACCEPTABILITY TO AFFECTED CONSTITUENTS

We asked each of our respondents which of the three options would be most acceptable to constituent groups, and what controversies these options were likely to generate. Responses fell into two basic categories: 1) relative acceptability of individual options, and 2) constituent acceptance of any of the three options.

Relative Acceptability of the Three Options

1) Option #1, which varies the cost-share ratio for large and small group homes, was widely criticized for doing so. We heard that it would polarize ICF/MR providers and thereby lessen cooperation, that it would penalize existing large facilities designed to serve the multiply handicapped and discourage development of new ones, and that it would be hard to sell.

2) The options in which the state pays 100 percent for waivered services met with a mixed and strongly charged reaction. While counties thought it would make the plan easier to sell to their Boards, and some advocates like the idea, others insisted that the county should have some stake in the cost for all services as a safeguard against abuse. We concur, and add that the relatively small cost advantage is outweighed by the principle of county participation and control.

3) Options #1 and #3 were criticized for differentiating the cost-share ratio of state hospitals and group homes. While some differentiation might be acceptable, state hospital providers would clearly oppose a wide gap.

4) Some respondents liked the fact that Option #2 differentiates the least among the service alternatives, because they see it offering the most choice for appropriate placement. But many people, county respondents in particular, oppose this option because it also imposes heavy costs for all non-waivered services.

5) In general, the greater the variance in cost-shares among services, the greater the controversy the option would generate. Option #3 (most acceptable to counties because of overall costs) as well as Option #1 would be hard to sell to other constituents because of this discrepancy.

Constituent Acceptance of the Options

The clearest messages we heard are that none of the options will be acceptable to all constituents, and that all of the options are equally controversial. As presently construed, a variable cost-share ratio will probably generate heated controversy, especially from present service providers.

Based on our input, likely objections from various constituents to any of the three options are listed below.

1) From State hospitals:

* Reduction of state hospital populations is an "old issue" but also hospitals will apply the greatest pressure against the options.

* Counties will be penalized for using state hospitals even though utilization targets are met.

* Reducing state hospital populations will be a threat to hospital communities, both because of lost jobs and fear of an influx of severely retarded patients.

* All providers should be in a competitive position and the options skew the advantage greatly against state hospitals.

2) From State hospital employees:

* AFSCME is not likely to support any of these three options.

* Employees feeling job insecurity may not want to cooperate in the process of preparing clients for movement.

3) From ICF/MR providers:

* Providers are likely to object to "changing the rules" from a policy of growth to one of reduction, saying "I have invested a lot, and this is how the state treats me?"

* If counties must pay a greater share, an exception should be made for Class B facilities for the multiply handicapped

* Per diem rates for ICF/MR facilities need to be changed so that larger group homes can modify themselves to become small group homes without loss of income.

4) From Advocacy groups:

* Fiscal incentive should not determine placements.

* People should not be moved out of ICF/MR's before waivered services are adequately developed.

5) From Client families:

* Parents will be concerned that their children will be forced out of "secure placements" in group homes.

* Parents are particularly concerned with the issue of choice and would oppose options which limit it. A parent might feel forced to keep a child at home because an appropriate group home placement was not available. For example, there are only about three small group homes in the state now for children requiring ongoing medical care.

* Parent expectations about care need to change. Already the new services have been "hard to sell" because of a "lack of service identity". Families of mainstreamed children have been led to expect that ICF/MR placements will be available after high school graduation.

6) From County administrators and Boards

* Some people will charge that "DPW is against counties", that they are cutting their own costs to the detriment of counties.

* The share of costs for MR services will be greater than for other services, and will cut into other programs.

* Boards are unwilling to increase any services.

* The options are unfair to counties who have already moved clients. Many counties feel they are already placing appropriately.

* Sparsely populated counties will have the greatest difficulty developing new services, and may need to move clients to more densely populated counties.

* If the state dictates "appropriate care" by determining cost, county flexibility is diminished.

* Communities may not be likely to accept more mainstreaming of MR clients.

Summary

Objections to one or all of the options is diverse and widespread. Many of the concerns stem from the perception that change is being "forced" by imposing heavy cost penalties and that placement choices are being limited, even where counties are meeting previously established DPW goals. The options as they are presently construed are not likely to gain acceptance.

OTHER ASSESSMENTS

We asked all respondents to give us additional recommendations or comments about the policy options and the variable cost-share ratio in general. These are summarized under topic headings below.

New clients in the waivered services system

There is some uncertainty about who will be eligible for the new waivered services and whether quotas will be set for new clients.

A number of respondents see the waivered service system as ideal for addressing the needs of mainstreamed high school graduates and young children at home or in foster-care homes. They believe that investment in providing services to these groups could pay off by facilitating the long-range "normalization" of this population and thereby avoiding future institutional costs and "crisis" placements. However, they wonder whether many of these children will be denied services or placed on waiting lists because the system will not be set up to accommodate large numbers of new clients.

According to one respondent, about three percent of the Minnesota population is mentally retarded and about one percent (40,000 people) need placements. The MA system serves the needs of about 8,000 MR clients, and the family subsidy program is limited to 200 clients. Thus there are many more who might potentially be served.

Transitions for MR clients

In an MR client's life cycle, placement needs may vary and change. The system should recognize that some will need temporary or transitional services in group homes or respite care, and such movement should not be seen as a setback.

Appropriate care may also not always mean the least intensive level of care in which a client might be served. Moving is disruptive and upsetting even for normal-IQ people and movement should be planned to minimize failure.

As the system changes, group home clients will be moved into waivered services and state hospital clients into group homes. This may require more intensive staffing and structural changes in the group homes to accommodate the needs of the new kinds of clients. A mechanism is needed whereby such changes can be financed, especially to afford smaller group homes the capacity to care for the severely retarded .

In the past, some clients who needed less intensive services were placed in ICF/MR's or state hospitals because of the limit on in-home clients. Now the opposite may become true.

More consideration to the unknowns

MA costs are only a small piece in a complex "system puzzle". Other pieces are still unknowns. More study and planning is needed to integrate DPW policy changes into the whole MR care system.

Some of the "missing pieces" we heard about are:

* What will development of waivered services look like? What will it cost? Where will the money come from? Who will train providers and caseworkers? Which clients will be served best in each category? What quality assurances will there be? Local county directors have very little idea.

* How will Development Achievement Centers (DAC's) affect the total costs of the new system?

* What is the state's long-range plan for use of state hospital facilities?

* Will there be enough available programs to implement the new system? Who will develop them? How will present providers and their employees be brought into the process?

* What guarantees do counties have that DPW will not change its policies again after they have invested in developing a new system?

Issue-based vs. cost-based policies

One respondent suggested that DPW consider dealing with one issue at a time and working with it across the system, rather than implementing a cost-incentive plan.

For example, 50 percent of state hospital admissions are for respite care (a stay of 90 days or less). Finding alternative ways of providing respite care might be an effective way of cutting the number of hospital beds. A feasibility study might be warranted for this idea.

Another issue might be the 200 children now living in state hospitals. The state and county could work out a package of incentives for getting these children into other settings.

Still another issue could be the re-deployment and re-training of state hospital employees to develop and administer waivered services. An incentive package which would address the needs of these people would also serve the smooth flow of waivered service development.

Summary

The cost-share ratio plans do not directly address many of the issues which arise from a policy of developing a new service delivery system. How will new clients become eligible for services? What mechanisms will be built in for changes in individual clients' service needs? How will the waivered services be developed and implemented? Would an issue-focused approach be more effective than a cost incentive in encouraging change?

INCENTIVES AND DISINCENTIVES

THE THREE OPTIONS AS DISINCENTIVES

We have seen that all three proposed policy options in this study constitute "disincentives" rather than "incentives", to development and use of waivered services. The ways in which the tested policy options act as disincentives include:

* Counties do not share in the financial savings which result from the use of the less expensive alternative services

* Counties are heavily burdened, especially in the first few years, by increased overall costs even though they are reducing utilization of large facilities

* Many constituents will object to the fact that counties may either cut services or utilize new services inappropriately simply as a means of avoiding further penalties

* Most of the financial savings resulting from the new services goes to the state, even though counties are assuming the burden of developing the new services

* Disincentives with wide disparities in cost-ratio shares reduce freedom of choice for caseworkers and clients

* Two of the policy options would penalize counties for moving state hospital clients to Class B facilities.

MOVING FROM DISINCENTIVES TO INCENTIVES

We have also seen that there will indeed be overall cost savings as a result of the counties' movement of clients into more community-based settings. We think it is reasonable to allow the counties to share equally at least in the benefits of these reduced costs, which they would do under the present cost-share policy.

We also think there are good reasons to make it even more "profitable" to counties when they succeed in the difficult task of developing a new set of services and meeting state utilization targets. These reasons include:

* The administrative burden faced by the counties in putting a new system in place and creating safeguards for clients

* The leverage that a "reward" system would give them in selling the new program in their communities

* The principle of "positive reinforcement" as a more effective strategy in achieving behavioral change

* The immensely greater likelihood of constituent acceptance in a program where everyone wins and no one loses.

What the Incentive Should Do

We have tried to imagine what a true fiscal incentive would look like. We were guided by the following principles:

* The incentive should encourage counties to develop and utilize waivered services without losing cooperation from existing providers

* The incentive should allow sufficient development time for re-training of present providers who may wish to develop new services and for counties to develop quality control safeguards

* The incentive should reward counties for meeting the state's utilization targets

* The incentive should make it possible for continued movement of clients into waivered services to increase savings to the county over time

* The incentive should offer a positive impetus to counties to incur upfront development costs with the expectation that savings will be realized later

* The incentive should allow the state to share in the cost savings of the new services

What the Incentive Should Not Do

* The incentive should not put pressure on caseworkers to place clients solely on cost factors
* The incentive should minimize "polarization" of constituencies
* The incentive should not penalize counties for appropriate placements (such as movement of multiply handicapped clients from state hospitals to Class B ICF/MR's)
* The incentive should not increase the cost-share to counties for ANY services until enough new, less expensive services are in place so that their costs will not increase more than the state's projections of reasonable client movement

WHAT WOULD AN INCENTIVE LOOK LIKE?

After studying the criteria outlined above and the projections of client movement done by the sample counties, we designed a variable cost-share ratio plan which might succeed in encouraging development of waivered services with minimal objections from counties and other stakeholders.

Under this plan, the present cost-share ratio would be maintained in 1984. In 1985 the ratio would change for waivered services, and in 1986 the ratio would change for state hospitals. This would allow counties time to move clients from state hospital settings without incurring increased costs. The cost-share ratio for ICF/MR's would not change at all.

Under this plan, the state and county would pay the following percentages of the non-federal share:

	State	County
A. In-home family support services (beginning 1985)	95%	5%
B. Other waivered services: (beginning 1985)		
Developmental training homes (foster care)	95%	5%
Supervised living arrangements (SLA'S)	95%	5%
Semi-independent living services (SILS)	95%	5%
C. Small group home (15 or less)	90%	10%
D. Large group home (16 or more)	90%	10%
E. State hospital (beginning 1986)	88%	12%

We are not suggesting a penalty for counties who exceed their utilization targets. Were such a penalty imposed at all, we believe it should apply only to state hospitals. However, we believe that it should not be necessary to impose a penalty because of the positive motivations the plan offers to move clients.

Table 12 shows the total cost projections and costs to the state and the sample counties under this plan, using the counties' projections for client placement.

How the Plan Meets Incentive Criteria

1) Counties are immediately encouraged to develop and utilize waivered services by the 95-5% cost-share ratio.

2) Cooperation from present providers is not lost because no one "loses", at least according to the sentiments expressed in reaction to the three options explored in this study:

* ICF/MR cost-share rates do not change.

TABLE 12.

SAMPLE COUNTY MA UTILIZATION AND COSTS FOR MR FACILITIES, PROJECTED 1984-87

Additional Policy Option

	Type of Service	1984 No. of Clients	1984 Cost	1985 No. of Clients	1985 Cost	1986 No. of Clients	1986 Cost	1987 No. of Clients	1987 Cost
A	In-home support 95%	111		175		254		326	
	State share		$ 321,234		$ 561,400		$ 855,726		$ 1,153,062
	County share		35,742		29,575		44,958		60,636
	Federal share		403,041		667,275		1,017,016		1,370,504
	Sub-Total		$ 760,017		$ 1,258,250		$ 1,917,700		$ 2,584,202
B	Other waivered services 95%	197		478		671		893	
	State share		$ 865,618		$ 2,341,244		$ 3,471,083		$ 4,873,994
	County share		96,333		123,324		182,512		256,291
	Federal share		108,864		2,782,438		4,124,637		5,791,998
	Sub-Total		$ 1,070,815		$ 5,247,006		$ 7,778,232		$ 10,922,283
C	Small ICF/MR 90%	1172		1158		1108		1074	
	State share		$ 12,095,040		$ 13,334,370		$ 13,680,476		$ 14,166,060
	County share		1,345,456		1,482,240		1,521,284		1,575,558
	Federal share		15,173,884		16,727,310		17,169,028		17,771,478
	Sub-Total		$ 28,614,380		$ 31,543,920		$ 32,365,788		$ 33,513,096
D	Large ICF/MR 90%	1043		1001		981		956	
	State share		$ 10,763,760		$ 11,526,515		$ 12,112,407		12,609,640
	County share		1,197,364		1,281,280		1,346,913		1,402,452
	Federal share		13,503,721		14,459,445		15,196,671		15,818,932
	Sub-Total		$ 25,464,845		$ 27,267,240		$ 28,655,991		$ 29,831,024
E	State hospital 88% after 1985	898		830		757		683	
	State share		$ 16,061,628		$ 16,627,390		$ 16,606,726		$ 16,781,496
	County share		1,786,122		1,848,410		2,266,044		2,289,913
	Federal share		20,151,120		20,859,560		21,308,036		21,532,258
	Sub-Total		$ 37,998,870		$ 39,335,360		$ 40,180,803		$ 40,603,667
	Totals - All Services	3421		3642		3771		3932	
	State share		$ 40,107,280		$ 44,238,020		$ 46,726,418		$ 49,584,252
	County share		4,461,017		4,917,728		5,361,708		5,584,850
	Federal share		49,340,630		55,496,028		58,810,388		62,285,170
	TOTAL		$ 93,908,927		$104,651,776		$110,898,514		$117,454,272

* State hospitals, who have known for some time that their populations will be reduced, have two years before the county pays a greater share, time they can use to re-train staff, create new jobs, and participate in the development of the new services.

* Advocates, caseworkers and client families need not feel that inappropriate placements are made so that counties will avoid penalties.

3) Counties have an additional year of grace before their share of payments for any services are increased, during which time they can develop new services with adequate safeguards, secure cooperation from Boards and taxpayers based on the potential cost savings, and begin client movement according to their own projections of what they can realistically achieve.

4) The counties which meet their state hospital utilization targets will not have to pay a disproportionate share for state hospital clients in 1986 (the first year in which their rate increases) because they will have moved sufficient numbers of clients to other services.

5) The percentage of cost increase (accounted for by inflation and new clients) to counties goes down from 9 percent in 1986 to 4 percent in 1987 despite the higher cost-share for state hospital placements. This is a net cost savings, and it happens because of the movement of more clients into waivered services. Moreover, we would expect even greater savings in subsequent years.

6) If no waivered services were developed, and if the present cost-share policy were maintained, we would expect costs for ICF/MR's and state hospital services to increase by at least 12 to 15 percent per year, not including costs for new clients. However, once the incentive plan takes effect, even including the influx of new clients neither the state nor the counties incur more than a 9 percent increase in any year, and the rate increase should continue to decline. Thus the plan would meet federal requirements that the waivered services cost less than the present system.

7) The small net "savings" even in the first two years combined with the potentially greater savings in the future should encourage counties to invest time and even some funding in the development of waivered services, especially if the state or federal government makes development money available.

8) The state shares in the reduction of cost increases which result from client movement. Its cost increase between 1985 and 1987 remains constant at 6 percent, compared with an increase of 11 percent in 1984.

9) Because the incentive plan is based on caseworkers' own projections of appropriate movement of clients into waivered services, the counties can save money without fear of inappropriate placements.

10) ICF/MR providers will not be polarized because small and large facilities have the same cost-share ratio. State hospital providers will have less reason to complain that they are treated differently from ICF/MR's. Advocates will be satisfied because waivered services are rewarded but the counties will still share in the "risk" by paying some of the costs. Caseworkers will not be pressured* by county Boards to cut costs regardless of client needs.

11) Movement of multiply handicapped clients from state hospitals to Class B ICF/MR's will not "cost" the counties anything extra.

RECOMMENDATION: DESIGNING AN INCENTIVE PLAN

If the state wants its plan to act as an incentive, we recommend that it meet the criteria outlined in this section.

The incentive plan we have developed offers a policy whereby everyone "wins". The state and the counties save money (as is required for federal approval of the waiver request). Present service providers have time to re-direct their efforts and take part in the development of new services. Counties have time to assure that quality services will be developed, and to educate their communities about the advantages of the policy change. The goals of deinstitutionalization and "normalization" are served at minimal cost.

While an incentive plan has a number of desirable qualities, it does still create administrative difficulties, some inequities will necessarily remain, and several respondents will be opposed to having cost determine level of care in any way. DPW may wish to consider other means of achieving the de-institutionalization goals of its plan than by altering the present cost-share ratios.

We think that an incentive plan such as proposed in this section would be well-received, but this is conjecture. Perhaps this report could be circulated for response.

RECOMMENDATIONS: ENCOURAGING WAIVERED SERVICES

Even the best of incentive plans will not work unless high quality services are developed and caseworkers are knowledgeable about how best to use them. Quality of care should be paramount in any policy, if it is to gain acceptance and assure long-term benefits to the mentally retarded.

While waivered services were not directly the focus of this study, it was difficult for our respondents to separate the changes that will be necessary to establish a whole new system of services from the changes that would result from a fiscal incentive policy aimed at facilitating client movement in that system.

DPW staff suggested that the additional stress to counties and providers of a fiscal incentive plan might "overload" the system if introduced in the developmental stages of waivered services.

we concur, and would like to suggest more immediate steps which would facilitate development of the new system. Once these steps have been taken, the state would also be in a better position to judge the merits of a fiscal incentive plan, and counties and providers would be in a better position to profit by it.

Whether or not the state chooses to adopt a financial incentive plan, we recommend an integrated planning and implementation process. We see several critical elements to that process:

* An overall design plan for development of waivered services, developed by considering the total impact of waivered services and by further exploring the feasibility and consequences of an incentive plan.

* A set of guidelines for developing and monitoring waivered services and appropriate placement of clients.

* A technical assistance package for counties to orient them to the new services and to provide assistance in funding, training, development, and application.

* An implementation plan which utilizes the knowledge and resources of current service providers and their staffs and affords them the opportunity to become providers of new services.

Design Plan

Many of the implications of the waiver request were not considered in this study, and other implications of developing a new system of community-based services lie outside of the waiver request itself. DPW is concerned with a total re-structuring of the MR system, which will include a cap on ICF/MR beds and consolidation of state hospital units, statewide admission and release criteria, MA payments to Development Achievement Centers (DAC's), an array of services not all of which are considered in our study, and services funded by the County Social Service Association (CSSA) as well as MA.

Many of the other policy implications of waivered services are in fact being studied by DPW. What we are suggesting here is an overview structure whereby studies such as this one are seen in a larger design context.

For example, for a fiscal incentive plan alone a number of questions have not been addressed in this study and yet remain critical to gain an understanding even of fiscal impact. Some of these questions are: What will be the total financial impact of the re-structured system? Could a consolidated system of payments be worked out to save administrative costs? How realistic are the cost projections in the waiver request? How will services not considered in this study (DAC's, respite care, homemaker services, case management) affect overall costs? How realistic are the sample county projections for client movement? How would an incentive plan be tied to a utilization target plan?

Moreover, these questions do not address the relationships among fiscal policy and administrative, programmatic and political impact.

We recommend that DPW continue to consult with the key "actors" in the MR system, many of them respondents in this study with the goal of developing an integrated long-range policy design. Perhaps a Task Force could be developed, with support staff to research overall policy implications, and charged with constructing an overall design plan.

Guidelines

Developing guidelines for admission and release criteria for all services, monitoring systems and safeguards, screening, licensing, appropriate care, appropriate limits on ICF/MR and state hospital utilization and enforcement, per diem rates, and evaluation should be the first step in, implementing any changes.

These guidelines should emerge from in-depth interviews with providers, advocates, county directors, and caseworkers; a review of a representative sample of cases; and a study of other states where waivered services have already been implemented.

They should be field-tested in a representative sample of counties to insure that they are understandable and comprehensive.

We recommend that such guidelines (which DPW is already planning to develop) be put in place prior to a decision about a fiscal incentive plan.

Technical Assistance

Many of the counties in our sample clearly need education and assistance in making the transition to decentralized and de-institutionalized care.

They need to learn how they can secure funding and overcome administrative hurdles to develop new services. They will certainly need additional resources to develop the new services; all but two of the sample counties clearly cannot afford to do it by themselves. They need to know more about the basic philosophy of "normalization" and its ultimate goals. Initially they will need someone to review their caseload and apply the state's guidelines on a case-by-case basis.

We recommend that a two-day training conference be planned for all counties, and that the state carry out its intention to contract with regional consultants to work with counties individually on an implementation plan.

This would help counties to set the new system in place before adding more administrative changes (which would be necessitated by a fiscal incentive plan).

Working with Present Service Providers

Staff in ICF/MR's and state hospitals are key resources in developing new services. Many also stand to lose their jobs if they do not participate in delivery of new services.

If the state contracted with some of these providers to assist in the transitional process, it would gain the benefit of their knowledge and also help them to finance development costs and re-training of employees to deliver* the new services.

APPENDIX A
SAMPLE COUNTY COMPOSITION
= =

SAMPLE COUNTIES:
NUMBER OF CASES FOR EACH STRATIFICATION VARIABLE
= =

METRO/NON METRO	NO. OF CASES
M = Metro	4
N = Non-Metro	12
Total	16

ICF/MR UTILIZATION	NO. OF CASES
H = High	4
M = Medium	8
L = Low	4
Total	16

STATE HOSPITAL UTILIZATION	NO. OF CASES
H = High	4
M = Medium	7
L = Low	5
Total	16

WELFARE CASELOAD RATIO	NO. OF CASES
H = High	5
M = Medium	7
L = Low	4
Total	16

HOSPITAL CATCHMENT AREA	NO. OF CASES
1 = Fergus Falls	2
2 = Willmar	2
3 = St. Peter	2
4 = Faribault	4
5 = Cambridge	2
6 = Brainerd	2
7 = Moose Lake	2
Total	16

COUNTY DISTRIBUTION FOR EACH STRATIFICATION VARIABLE

County Name	Metro N/M	ICF/MR Util.	SH Util.	Caseload Ratio	Catchment Area
Beltrami	NM	M	M	H	6
Carver	NM	M	M	L	3
Faribault	NM	H	H	L	3
Hennepin	M	M	M	M	4
Isanti	NM	L	L	M	5
Itasca	NM	M	M	H	6
Lake	NM	L	H	H	7
Mahnomen	NM	H	H	H	1
Mower	NM	M	M	M	4
Nobles	NM	H	L	M	2
Olmsted	M	M	L	L	4
Red Lake	NM	L	H	M	1
Renville	NM	H	L	M	2
Rice	NM	M	M	M	4
St. Louis	M	M	M	H	7
Washington	M	L	L	L	5

Rainbow Research, Inc.
10 January 1984

POLICY OPTION # I
WORKSHEET FOR ESTIMATING COUNTY'S SHARE OF COSTS 1984-1987

Type of Service	(A) 1984 County Share/ Client at present rate	(B) # of Clnts	(C) County Total	(A) 1985 County Share/ Client	(B) # of Clnts	(C) County Total	(A) 1986 County Share/ Client	(B) # of Clnts	(C) County Total	(A) 1987 County Share/ Client	(B) # of Clnts	(C) County Total
In-home support	$322 X		=	0 X		=	0 X		=	0 X		=
Other waivered services	$487 X		=	$258 X		=	$272 X		=	$287 X		=
ICF/MR's Small	$1,148			$1,280			$1,373			$1,467		
Large & Small	$1,148 X		=	$1,920 X		=	$2,059 X		=	$2,200 X		=
State Hospital	$7,982 X		=	$8,450 X		=	$8,964 X		=	$9,512 X		=
TOTALS		(B)	(C)		(B)	(C)		(B)	(C)		(B)	(C)

THIS WORKSHEET SHOULD BE USED AS THE BASIS TO ANSWER QUESTION # 2 FOR POLICY OPTION # /, PAGES 8 AND 9

INSTRUCTIONS: Write in the estimated number of clients in each service category for each year in Column B. Multiply this number by Column A and write the total in Column C. Fill in the totals for Columns B and C at the bottom of the page.

Rainbow Research, Inc.
10 January 1984

POLICY OPTION #2
WORKSHEET FOR ESTIMATING COUNTY'S SHARE OF COSTS 1984-1987

Type of Service	(A) 1984 County Share/ Client at present rate	(B) # of Clnts	(C) County Total	(A) 1985 County Share/ Client	(B) # of Clnts	(C) County Total	(A) 1986 County Share/ Client	(B) # of Clnts	(C) County Total	(A) 1987 County Share/ Client	(B) # of Clnts	(C) County Total
In-home support	$322 X		=	$349 X		=	$377 X		=	$386 X		=
Other waivered services	$967 X		=	$258 X		=	$272 X		=	$287 X		=
ICF/MR's Large & Small	$1,192 X		=	$1920 X		=	$2059 X		=	$2,200 X		=
State Hospital	$1,987 X		=	$3371 X		=	$3742 X		=	$4191 X		=
TOTALS		(B)	(C)		(B)	(C)		(B)	(C)		(B)	(C)

THIS WORKSHEET SHOULD BE USED AS THE BASIS TO ANSWER QUESTION # 2 FOR POLICY OPTION #2, PAGES 12 AND 13

INSTRUCTIONS: Write in the estimated number of clients in each service category for each year in Column B. Multiply this number by Column A and write the total in Column C. Fill in the totals for Columns B and C at the bottom of the page.

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POLICY OPTION # 3
WORKSHEET FOR ESTIMATING COUNTY'S SHARE OF COSTS 1984-1987

Type of Service	(A) 1984 County Share/ Client	(B) # of Clnts	(C) County Total	(A) 1985 County Share/ Client	(B) # of Clnts	(C) County Total	(A) 1986 County Share/ Client	(B) # of Clnts	(C) County Total	(A) 1987 County Share/ Client	(B) # of Clnts	(C) County Total
In-home support	$322 X		=	0 X		=	0 X		=	0 X		=
Other waivered services	$489 X		=	0 X		=	0 X		=	0 X		=
ICF/MR's Large & Small	$1,178 X		=	$1,280 X		=	$1,373 X		=	$1,467 X		=
State Hospital	$1,787 X		=	$2,450 X		=	$3,284 X		=	$5,582 X		=
TOTALS		(B)	(C)		(B)	(C)		(B)	(C)		(B)	(C)

THIS WORKSHEET SHOULD BE USED AS THE BASIS TO ANSWER QUESTION # 2 FOR POLICY OPTION # 3, PAGES 16 AND 17

INSTRUCTIONS: Write in the estimated number of clients in each service category for each year in Column B. Multiply this number by Column A and write the total in Column C. Fill in the totals for Columns B and C at the bottom of the page.

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WORKSHEET FOR ESTIMATING COUNTY'S SHARE OF COSTS 1984-1987 UNDER THE PRESENT COST SYSTEM (STATE 90%, COUNTY 10% OF NON-FEDERAL SHARE)

Type of Service	(A) 1984 County Share/ Client	(B) # of Clnts	(C) County Total	(A) 1985 County Share/ Client	(B) # of Clnts	(C) County Total	(A) 1986 County Share/ Client	(B) # of Clnts	(C) County Total	(A) 1987 County Share/ Client	(B) # of Clnts	(C) County Total
In-home support	$ 322 X		=	$338 X		=	$ 355 X		=	$373 X		=
Other waivered services	$ 489 X		=	$ 516 X		=	$545 X		=	$575 X		=
ICF/MR's Large & Small	$ 1,148 X		=	$1,280 X		=	$1,373 X		=	$1,467 X		=
State Hospital	$ 1,989 X		=	$2,227 X		=	$2,495 X		=	$2,794 X		=
TOTALS		(B)	(C)		(B)	(C)		(B)	(C)		(B)	(C)

THIS WORKSHEET SHOULD BE USED AS THE BASIS TO COMPARE COSTS OF EACH POLICY OPTION WITH PRESENT COSTS.

INSTRUCTIONS: Write in the estimated number of clients in each service category for each year in Column B. Multiply this number by Column A and write the total in Column C. Fill in the totals for Columns B and C at the bottom of the page. Now compare the totals on this Worksheet with the totals for each proposed policy option to determine whether the costs to your county will increase or decrease.

Rainbow Research, Inc.
10 January 1984

SAMPLE

POLICY OPTION # 1
WORKSHEET FOR ESTIMATING COUNTY'S SHARE OF COSTS 1984-1987

Type of Service	(A) 1984 County Share/ Client at present rate	(B) # of Clnts	(C) County Total	(A) 1985 County Share/ Client	(B) # of Clnts	(C) County Total	(A) 1986 County Share/ Client	(B) # of Clnts	(C) County Total	(A) 1987 County Share/ Client	(B) # of Clnts	(C) County Total
In-home support	$322 X 0 =	0	0	0 X	9 =	0	0 X	19 =	0	0 X	28 =	0
Other waivered services	$989 X 0 =	0	0	$258 X	20 =	5,160	$272 X	31 =	8,432	$287 X	62 =	17,794
ICF/MR's Small	$1,148	130	149,240	$1,260	127	160,020	$1,373	123	168,879	$1,967	120	176,040
Large & Small	$1,148 X 140 =	160,720	$1,920 X	139 =	266,880	$2,059 X	138 =	284,142	$2,200 X	136 =	299,200	
State Hospital	$1,989 X 127 =	252,603	$2450 X	117 =	520,650	$2,784 X	106 =	526,304	$2,582 X	96 =	535,872	
TOTALS		397	$562,563		413	$955,250		417	$989,757		442	$1,028,906
		(B)	(C)		(B)	(C)		(B)	(C)		(B)	(C)

THIS WORKSHEET SHOULD BE USED AS THE BASIS TO ANSWER QUESTION # 2 FOR POLICY OPTION # 1, PAGES 8 AND 9

INSTRUCTIONS: Write in the estimated number of clients in each service category for each year in Column B. Multiply this number by Column A and write the total in Column C. Fill in the totals for Columns B and C at the bottom of the page.